South Carolina Workers' Compensation Commission
1612 Marion St.
P.O. BOX 1715
Columbia, SC 29202-1715
803-737-5723

WCC File #: _____
Carrier File #: _____
Carrier Code #: _____
Employer FEIN #: _____

Claimant's Name: _____ SSN: ___-___-_____ Employer's Name: _____

Address: _____ Address: _____

City: _____ State: _____ Zip: _____ City: _____ State: _____ Zip: _____

Home Phone: (___) ___-_____ Work Phone: (___) ___-_____ Insurance Carrier: _____

Preparer's Name: _____ Law Firm: _____ Preparer's Phone #: (___) ___-_____

Application for Lump Sum Award

The claimant named above has been granted an award of compensation and the award has been paid in periodic payments for not less than six weeks.

The claimant requests a lump sum payment of the award, reduced to present day value, according to the Regulations of the Commission.

(Check One)

☐ The employer and its representative consent to the payment of the award in lump sum as shown by the letter attached to this application.

☐ The employer and its representative object to the payment of the award in lump sum as shown by the letter attached to this application.

In this space, please state the reason(s) for requesting lump sum payment and intended use of the money.

_____

_____

_____

_____ _____
Claimant / Representative Date

Do not write in this space.

Approved: ☐ Set for hearing: ☐

_____
Commissioner

File this form with the Claims Department. Refer to R.67-1605 and R.67-1606 for additional information. If the claimant is not represented, the Claims Department will contact the employer's representative to inquire if it consents to a lump sum payment. If either the employer's representative or the Commissioner do not agree to payment in lump sum, a hearing will be set automatically and the parties notified.